The American Board of Cosmetic Surgery Written Testimony for Medical Board of California Hearing
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AMERICAN BOARD
OF COSMETIC SURGERY

Good afternoon. Thank you for taking the time for this public hearing. Sadly, and despite the fact that we submitted application three years ago, the review process, particularly of the American Academy of Cosmetic Surgery's fellowship, has all appearances of being rushed through, is lacking and appears quite bias.

The bias comes from a lackluster effort in the review, whereas the reviewer, board certified by our competitor, the American Board of Medical Specialties, despite being invited multiple times, never bothered to speak with a fellowship director, visit a fellowship program, nor speak with a fellow. All of which forces us to question original intent in according our board its rights to commercial free speech.

Much of the appearances of these actions are what the Supreme Court addressed in its decision on North Carolina Board of Dental Examiner v. FTC, regulating bodies across the country, inclusive of state medical boards, are now recognizing that past decisions on commercial speech may be anti-competitive and a violation of our monopoly laws. The Supreme Court ruling stated that "this type of "self-regulation" is common among state licensing boards. But it has the natural tendency to become anticompetitive. The Supreme Court went on to state in its opinion that State licensing boards composed of market participants do not enjoy automatic immunity from anti-trust laws and if actions appear anti-competitive, they can be held personally liable.

These actions clearly place the American Board of Cosmetic Surgery's physician rights of commercial free speech, along with our right to compete in an open marketplace gravely at risk. Even more

concerning is how complete misconceptions, mostly driven from our opposition within the ABMS, places patient safety and care at risk, the very care we all take an oath to protect.

There have been many false claims by our opposition that cannot go unchallenged in the public record. Among those included are:

ABCS diplomates have inappropriate training

ABCS diplomates lack knowledge of anatomy

No one-year training leads to certification

Experience route is not valid

ABCS diplomates have higher rates of medical board violations

Fellows just assist and watch surgery

The truth and reality of the ABCS is starkly different than these claims of our opposition. ABCS diplomates have completed an ACGME/AOA surgical residency prior to fellowship training. All fellows are experienced and qualified surgeons prior to the start of their fellowship training. All diplomates have full knowledge of anatomy from medical school and ACGME/AOA primary residency followed by a dedicated cosmetic surgery fellowship. It is nonsensical to suggest that one-year fellowship does not lead to certification. Examples include spine surgery, hand surgery, facial plastic and reconstructive surgery, sleep medicine, among many others. Also, the experience route is indeed common in the evolution of all boards. Many of those boards a recognized by the Medical Board of California. In addition, and somewhat ironic, to qualify for the ABCS board certification exam, one must have either: ABMS, AOA, RCPSC or ABOMS board certification.

To impede competition from the ABCS, our opponents, or shall we say, our competitors within ABMS, group all physicians who call themselves cosmetic surgeons into this category and inflate the reprimand rate without regard to ABCS certification. The rate for serious violations is the same or lower among ABCS diplomates compared with our ABMS competitors. Major professional liability carriers, for example, Medical Protective give ABCS diplomates an additional discount due to their lower risk pool based on statistics and history.

ABCS diplomates sit on AMA committees pertaining to patient safety and its members contribute as expert witnesses to state medical boards including the Medical Board of California. Multiple states have ABCS diplomates serving as medical board members. Even California has had an ABCS diplomate serve as a member.

Fellows are co-surgeons during fellowship with progressive responsibility and are active in every aspect of patient care. Our fellows graduate with an average of over 600 cases.

Contrary to what has been touted, it is very common for different primary specialties to apply to one subspecialty board, examples of which, include all of the following boards that are recognized by the Medical Board of California:

The American Board of pain medicine which is comprised of anesthesiology, neurologic surgery, urology psychiatry, physical medicine and rehabilitation.

The American Board of Sleep Medicine which includes anesthesiology, family medicine, internal medicine, pediatrics, psychiatry, neurology and otolaryngology.

The American Board of Hand Surgery includes general surgeons, orthopedic surgeons and plastic surgeons.

The American Board of Spine Surgery includes orthopedic surgeons and neurosurgeons.

Additionally, there is our powerful competitor from the ABMS, the American Board of Plastic Surgery which is comprised of general surgery, neurologic surgery, oral maxillofacial surgery, orthopedic surgery, otolaryngology, thoracic surgery and urology.

It should not go unnoticed that these last six primary specialty boards that are permitted to engage in fellowship training and eventual board certification by the American Board of Plastic and Reconstructive Surgery have not the primary education in full body anatomy alleged by our opponents at the last hearing. These remarks are thus, either disingenuous or, perhaps our opposition was not aware of these pathways to their own certification, however, I must correct the inconsistency as it may have influenced the public members though I am confident the physician members recognize its absurdity.

The bar continues to rise in physician board certification. Standards are not set by one organization as is recognized by many states and organizations including the American Medical Association, the Department of Labor, and Centers for Medicare and Medicaid services.

There are several recent regulatory decisions and opinions on board certification which make clear the importance of your decision today. First of which I had mentioned earlier, is the United States Supreme Court's ruling on, North Carolina Board of Dental Examiners versus the Federal Trade Commission.

Regulating bodies across the country inclusive of state medical boards are now recognizing the past decisions on commercial free speech may be anticompetitive and in violation of our monopoly laws. In addition, state medical boards are recognizing competing boards not only meet but raise the standard of physician board certification, enabling greater innovation in medicine that has been stifled by the control by one organization.

As stated earlier, the US Supreme Court decision cited that state licensing boards composed of market participants do not enjoy automatic immunity from antitrust laws and if actions appear to be anticompetitive, they can be held personally liable. In the case of this petition, it is not merely the case of plastic surgeons versus cosmetic surgeons, but much more broadly, the American Board of Medical Specialties versus the ABCS. This clearly demonstrates the drive of one organization to stifle competition through limiting its competitors rights to commercial free speech.

The U.S. Court of Appeals 5th Circuit ruled that the Texas Board of Dental Examiners could not prohibit two dentists from advertising themselves to the public as specialists in implant dentistry. Although the individuals have received credentials from the American Academy of Implant Dentistry, Texas State Medical Board, under the Texas administrative code, had prohibited them from advertising as such because the AAID was not among the nine officially recognized specialties of the American Dental Association. The West Texas dental decision upheld these individuals' rights to free commercial speech

declaring that the law was unconstitutional, as it violated the defendant's First Amendment right to engage in truthful, non-misleading commercial speech.

In addition, on September 10th, the Department of Justice, in an opinion letter regarding a Maryland bill to promote competition in certification explains and recognizes the importance of competition in physician board certification. Per Robert Potter, the Chief of the Competition Policy & Advocacy Section, Anti-Trust Division, of the Department of Justice, "The Division recognizes the critical importance of patient health and safety and the role of state legislators and regulators in determining the optimal balance of policy priorities as they regulate the provision of healthcare services. The Division encourages the Maryland legislature to consider ways to facilitate competition by legitimate certifying bodies, consistent with patient health and safety. Physicians, hospitals, healthcare consumers, insurers, and others can benefit from competition to provide cost-effective, high-quality certification services. Toward that end, the Division encourages drafters of the Bill to consider ways to allow for entry by additional, legitimate certifying bodies."

Board certification is evolving. Just as organizations within the American Board of Medical Specialties and other certifying bodies recognized by the state of California have, the ABCS has evolved to meet the needs of surgeons seeking certification, in its case, in contemporary safe and prudent cosmetic surgery.

Comparative analysis found that similar boards to the ABCS have been approved by the Medical Board of California for the purposes of advertising, which would clearly direct any impartial observer to deem our organization equivalent.

As with the American Board of Facial Plastic and Reconstructive Surgery and the American Board of Sleep Medicine, ABCS offers a fellowship-dependent certification subspecialty that has no associated residency programs in existence.

As the American Board of Facial Plastic and Reconstructive Surgery and the American Board of Sleep Medicine both have had experience pathways to certification, the retired ABCS experience pathway was far more rigorous than that of the American Board of Facial Plastic Reconstructive Surgery, which was approved by the Medical Board of California. In fact, the ABCS procedural requirements exceeded the facial plastic and reconstructive board by a factor of 10. The Medical Board of California granted equivalency to the American Board of Sleep Medicine when it granted fellowship waivers.

Dr. Krauss asked at the last hearing, if the ABCS is a more robust organization today than it was at the time of its last petition to the Medical Board of California what of its diplomates certified before this evolution? It is of the absolute highest importance for the Medical Board of California, as it sits today, to understand that this was a turf battle then as it is a turf battle now.

The ABCS was a very robust organization at that time. I am proud to say that our organization has evolved, and I hope that each of you can say the same for your respective boards and certifying organizations.

Considering the turf battle past and present, the Medical Board of California, at the time of the last petition, found the ABCS experience route which required 1000 cosmetic surgical procedures prior to eligibility to sit for the examination as ineligible for consideration for equivalency whereas the Medical Board of California found the 100 mixed plastic and reconstructive procedures sufficient to grant the American Board of Facial Plastic and Reconstructive Surgery equivalency for the purposes of advertising.

I hope that the current Medical Board of California would consider 1000 dedicated cosmetic surgical procedures as exceeding the requirements it endorsed of the American Board of Facial Plastic and Reconstructive Surgery of a mere 100 mixed procedures.

As the American Board of Facial Plastic and Reconstructive Surgery, the American Board of Sleep Medicine, and the American Board of Medical Specialties have not stripped diplomates of their certificates as they evolve, nor has the ABCS.

Such action, or absence of evolution, would absolutely restrict the advancement of medicine and further infringe upon the right of commercial free speech of highly qualified physicians and their organizations. The Medical Board of California has granted and continues to grant equivalency for the American Board of Facial Plastic and Reconstructive Surgery experience-route diplomates.

Please also remember that many ABMS-certified physicians have lifetime certification; perhaps some of you are among them. The ABMS has not stripped them of their certification simply because they were certified under pathways that have evolved to include, recertification or maintenance of certification. Nor has the Medical Board of California restricted their right to commercial free speech.

Furthermore, the Medical Board of California accepts, for example, emergency medicine physicians who have not completed a residency in emergency medicine. The American Board of Emergency Medicine did not strip its previously certified diplomates of their certification simply because residency training became required. In fact, many of the ABMS legacy Emergency Medicine Physicians are Directors and leading those very residencies in Emergency Medicine.

The law put into place in California in 1990 was enacted to prevent deception of the public. The American Board of Cosmetic Surgery agrees with the importance of transparency in certification. The American Board of Cosmetic Surgery has always required that diplomates advertise the area of their certification. For example, many ABMS/AOA board certified surgeons were eligible for the facial cosmetic surgery certificate via the experience route when it was available, not general cosmetic surgery certificate. In such instances, the diplomate is required to advertise the specific area of certification as opposed to the general statement “board certified by the American Board of Cosmetic Surgery.” The ABCS is not deceiving anyone.

As with the American Board of Facial Plastic and Reconstructive Surgery the American Board of Cosmetic Surgery requires the completion of primary surgical training. The review report has been critical of the ophthalmology group. Yet, this cannot be any more black and white. Ophthalmology is an ACGME/AOA surgical residency. Oculoplastic fellowship adds substantial surgical experience. Two years of cosmetic surgery fellowship following such experience affords a median of approximately 1200 procedures, in addition, which exceeds postgraduate year 7 status.

Our response clearly outlines the assertions including the requirements and recommended by the ad hoc committee, appointed by the American Academy of Cosmetic Surgery, having reviewed the ACGME requirements for all the different specialties that can apply to the general cosmetic fellowships. The process of assigning oculoplastic surgeons the second year of surgical training in cosmetic surgeon was not arbitrary and this process was clearly defined via the ad hoc committee.

AACS fellowships provide critical academic support in cosmetic training. The ABCS is very proud to supplement its application with the AACS information on scholarly activities and appointments of its

faculty as well as the academic support afforded its fellows in training. We regret that the format of this information did not the satisfy the expert report, however three business days-time, over the Thanksgiving week when many take vacation time for their families, is insufficient to homogenize and collate information that could have been requested three years ago when we entered our application. However, we provided this information, nonetheless.

Also, please note that it is critical to understand that most medical libraries do not have sufficient cosmetic surgery titles to support fellowship training. AACS fellowships meet this need as such material is afforded the fellows that would otherwise be unavailable in the hospital-library setting.

This is crucial to support greater patient safety and care. It is indeed useless to a cosmetic surgery fellow to visit a university medical library, though all have such access through the required faculties' academic appointments, that has little to no cosmetic surgery texts. Please understand that multivolume plastic and reconstructive surgery texts that have a volume, usually the last and smallest volume, on cosmetic surgery, is insufficient for fellowship training, preparing for ABCS examinations, or safe practice in cosmetic surgery.

Duty limits and moonlighting are of the utmost importance to the American Academy of Cosmetic Surgery as opposed to the false conclusions in the supplemental fellowship evaluation report. The AACS guidelines are presented and supported within the response letter. The AACS is clear and adamant on a limit of 80 hours in a workweek and that moonlighting may not interfere with the fellowship or the duty hour limits. Training in cosmetic surgery is inherently unlikely to present material challenges to the standard but it is required, surveyed, and enforced, nonetheless. Fellows' compliance with the standard with or without moonlighting, is strictly mandated. This is verified during the site visits as required by the AACS in multiple formats. Though the ACGME is willing to rely on residency logs, which may or may not be at times falsely entered, the site survey is required to examine the fellows' schedule as well as case logs and interview key staff in the office as well as the fellows themselves to ensure the standard is being met and not only alleged to be. In this manner, we adamantly feel that the AACS oversight is much more rigorous than the ACGME oversight which requires only paperwork. The ABCS is well aware of the fact that many ACGME programs no longer are subjected to site visits. The AACS fellowship directors convened this past January to discuss the removal of this expensive and time-consuming part of the fellowship review process. It was indeed the fellowship directors that agreed *en masse* that site visits are a critical part of program evaluation as substantive information beyond written records can be ascertained on site. The fellowship directors were also against using just telephonic interviews to supplement written site evaluations declaring that in person observation is too important to abandon. We do feel that the ACGME, in this manner, is under evaluating their residency programs, and should reconsider the value of active site visitation to ensure training guideline compliance. We are also disappointed that the Medical Board of California's reviewer did not bother to conduct a site visit for a Fellowship Program that was unknown to him, despite the open invitation to visit any one of his choosing.

As with the ABFRPS and many ABMS certifications, the American Board of Cosmetic Surgery certifies candidates engaged in training with leadership positions within board organizations or its associated academies or societies. Included in our response letter is the process where evaluations by the fellowship review committee mitigates conflict of interest.

There are critical patient safety needs that are fulfilled by the ABCS. Training, experience, and methodical certification in cosmetic surgery is both invaluable to public safety and is not being adequately performed via the ACGME and ABMS.

Equivalency, in the context of the law and regulation, is not to be defined or interpreted as identical, but of equal value. There are several differences inherent to accredited ambulatory surgery center-based training from hospital-based training that have been highlighted in our last presentation and responses as they serve to the advantage training, experience, and certification to the highest level in cosmetic surgery.

Contrary to the assertions presented by competitors and opponents of the ABCS application, the AACS members are not ABCS diplomates unless they are duly certified and maintain such certification. I expect the Medical Board of California and its expert reviewer understand this distinction, however, with this misunderstanding pervasive in the testimony of our opposition, I respectfully submit this clarification.

Why is there such opposition to the ABCS? First, these are elective surgical procedures and patients see providers directly rather than by a referral network.

Number two, revenue: our competitors and opposition from ABMS, do not want to give up the money these procedures generate for their diplomates that serve to secondarily support dues and contributions for our opposing organizations. Most are not covered by insurance and are directly paid by the patient.

Number three, how does one prevent competition? Commercial free speech restriction provides an unlawful, but handy pathway, all of which is driven by our competitors within the ABMS under the guise of patient protection. In reality it is the means to silence our voice directly to the public to ensure marketplace control and regulatory capture.

Disallowing the ABCS physicians' right to commercial free speech, when we meet all the criteria demanded by the State of California, places the very issue of patient care safety at risk- the issue that we have a collective duty to protect.

Competing boards within the ABMS all too often wish to make this an us versus them battle; this is a battle that is for control, power and financial gain rather than patient safety and care. If this were about patient safety our opposition would be seeking to restrict our ability to practice. They are not doing this, in fact, our opposition, at the last hearing said that we may go on continuing our scope of practice, however we should not be allowed to state or advertise that we are board certified. Our opposition, therefore, has summed up their very intent, which is not to protect the public from the procedures and scope of practice in which we engage, but to restrict our commercial free speech in advertising our board certification.

Patient safety is clearly at stake; please do not let your bias as either an ABMS certified physician or your experience predominantly with ABMS certified-physicians cloud your ability to duly evaluate our organization. It is frequently reported that Aesthetic surgery remains a weakness for many plastic surgery residency programs as aesthetic procedures are often performed in private practices.

This fact is highlighted by the predominance of aesthetic surgery fellowships that are based in private practices that are not ACGME-accredited. Aesthetic fellowships remain popular training opportunities

for graduates to obtain additional credibility and confidence performing aesthetic surgery. Significant variability persists for many aesthetic procedure categories during plastic surgery residency training. Greater efforts may be needed to improve the aesthetic surgery experience of plastic surgery residents. These are not our words but from the Aesthetic Surgery Journal 2017 volume 37(5) pages 582 to 587, Disparities in Aesthetic Procedures Performed by Plastic Surgery Residents.

Further, from A Survey of Cosmetic Surgery Training in Plastic Surgery Programs in United States from Plastic and Reconstructive Surgery 122:1570 in 2008, the information collected revealed significant differences in opinions between program directors and senior residents. Senior residents felt deficient in facial cosmetic, minimally invasive, and recently developed body contouring techniques. On the basis of these results and the authors' experience in resident education, changes in cosmetic surgery training are suggested.

Fewer plastic surgery programs offered a specific cosmetic surgery rotation in 2009 as compared with 2006. Residents received only 3 to 4 months of cosmetic training when such rotations were allowed, from Cosmetic Surgery Training in Plastic Surgery Residency Programs in the United States: How Have We Progressed in the Last Three Years? This was in follow-up to the preceding data.

From A Review of General Cosmetic Surgery Training Fellowship Programs Offered by the American Academy of Cosmetic Surgery, as published in the Journal of Oral and Maxillofacial Surgery in 2015 the conclusions included that dedicating one's practice exclusively to cosmetic surgery requires additional post-residency training owing to the breadth of the field. The AACS has created comprehensive fellowship programs to fill an essential part of the continuum of cosmetic surgeon education, training, and experience. This builds on the foundation of their primary board residency program.

As presented in the last hearing, we demonstrated the strength not only in the median number of procedures participated in by fellows in cosmetic surgery - which is in the mid-600s as opposed to 150 in plastic and reconstructive surgery programs – however, our trainees have already been trained as qualified surgeons and are at a postgraduate training year that is greater than plastic and reconstructive surgery residency and means that our fellows are at a level of maturity that plastic surgery residents have not yet attained. In other words, plastic and reconstructive surgery residents are residents when they are receiving their cosmetic training, limited as it is as per their own research, whereas AACS fellows have already completed a primary surgical residency.

We are gravely concerned and disappointed by such opposition from our competitors within ABM. The clear anti-competitive intent and bias truly prohibits the enhancement of patient safety and care, especially within a specialty attracting under-qualified doctors wishing to capitalize on consumer demand and profit from offering cosmetic procedures, despite minimal or no training in cosmetic medicine.

We must work collectively to ensure patient safety; it is for that very reason that the ABCS was founded and continues to exist. It was created because no board certification was adequately certifying surgeons in cosmetic surgery. Yet procedures are performed more and more by under-qualified practitioners. As can be seen in the recent Supreme Court decision on anticompetitive practice of state boards along with the previously mentioned September 10th Department of Justice, Chief of Antitrust's opinion, prohibiting competing boards such as the ABCS, that meet today's higher standards in California's criteria in

physician board certification, perpetuates the growth of a monopoly and anticompetitive practices that stifle innovation in medicine and places the very patients we take an oath to protect at great risk.

Our competitors and opponents, as stated in their testimony last hearing, are not trying to restrict us from performing cosmetic surgery, they are trying to prohibit us from advertising our board certification. However, as demonstrated by an exacting certification program, a now historic but exceedingly rigorous experience route, high PGY training level, high procedural number, depth and diversity in fellowship training, why would the Medical Board of California not want the California public to be allowed to see that a surgeon was certified by the American Board of Cosmetic Surgery?

Wouldn't the Medical Board of California prefer to avail its public of visibility to this certification, helping patients find a provider that has been appropriately trained in cosmetic procedures? Would the Medical Board of California prefer that a patient not be able to see the difference between a practitioner trained at a weekend-course in liposuction versus a surgeon, with primary ACGME/AOA residency training, a primary surgical board certification, a subsequent rigorous one year dedicated cosmetic surgery fellowship training program with median of over 600 cosmetic procedures, a psychometrically evaluated and validated oral and written examination, ongoing monitoring of adverse board action in any state via the FSMB, maintenance of certification, as well as continuing medical education dedicated to cosmetic surgery?

Furthermore, if the Medical Board of California has concerns about ABCS diplomates who were certified during the evolution of the ABCS by the experience route please be advised by evidence provided today and in our response to the expert's supplemental questions, that our experience route was far superior to that of the American Board of Facial Plastic and Reconstructive Surgery, an organization that was approved for equivalency in advertising by the Medical Board of California.

I urge you to vote for the truth and not in favor of our ABMS competitor and opposition's agenda. The bill that was put in place in 1990 was to prevent deceptive advertisement. The ABCS is not deceiving anyone. Limiting advertising board certification to one group is clearly anticompetitive and does not serve public interest. Only through collaboration, seeking the highest level of training, performance and integrity, will we give the public the best and safest results in cosmetic surgery. Credible certifying entities should work together to educate and build awareness for the public to better ensure patient safety and care.

Allow the ABCS it's right to commercial free speech. We meet all the criteria demanded by the State of California. Our training and certification processes well exceed today's standard and that of similar organizations approved by the Medical Board of California. We have presented ourselves openly and comprehensively to the scrutiny of the Medical Board of California for the last three years, since our submission. Respectfully, and earned through thorough affirmative argument and exhaustive evidentiary support, I, as the president of the American Board of Cosmetic Surgery, request a motion and vote to approve our request for equivalency for the purposes of advertising.